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Fracture risk is a class effect of glitazones

Robert Short LONDON

Treatment with thiazolidinediones (glitazones) for type 2 diabetes has been found to increase the risk of fractures in women. Pioglitazone has now joined rosiglitazone, as the subject of a US Food and Drug Administration alert for fracture risk.

Takeda, the makers of pioglitazone (contained in Actos, Actosplusmet, and Duetact), and GlaxoSmithKline, the makers of rosiglitazone (contained in Avandia and Avandamet), have contacted US healthcare professionals setting out the evidence on fracture risk and recommending that they consider this risk when starting or treating women with type 2 diabetes with these agents.

The statement on pioglitazone was posted on 9 March as an FDA MedWatch safety information alert. Takeda reported findings from an analysis of its clinical trial database, comparing patients treated with pioglitazone (more than 8100 patients) with a comparator (more than 7400 patients given placebo or active agent). The analysis showed an increased risk of fractures in women taking pioglitazone compared with women taking a comparator.

Most of the excess fractures were in the distal upper limb (forearm, hand, and wrist) or distal lower limb (foot, ankle, fibula, and tibia).

The incidences of fractures in the pioglitazone and comparator groups were 1.9 and 1.1 per 100 patient years. The excess risk of fractures for women in this dataset is, therefore, 0.8 fractures per 100 patient years of use.

The fracture side effect with a thiazolidinedione was first discovered in December 2006 in the ADOPT study (a diabetes outcome progression trial; *N Engl J Med* 2006;355:2427-43).

The primary goal of the study was to compare glycaemic control with rosiglitazone relative to metformin and to glyburide monotherapies in 4360 randomised patients. In a late finding published as a "note added in proof," however, more women in the rosiglitazone group had upper limb fractures involving the humerus and hand.

JONATHAN PLAYER/REX

UK report recommends better planning for phase I drug trials

Susan Mayor LONDON

The first trials of new drugs in humans should be planned much more carefully, with the same clarity of purpose, design, and analysis as for studies supporting drug licensing, a report published this week recommends.

The report, published by a working party of the Royal Statistical Society, was prompted by the TGN1412 drug trial last year in which six healthy volunteers, including Navneet Modi (above) experienced severe immune reactions (*BMJ* 2005;332:683). It found that "the trial design was not well suited to its objectives of testing the safety and tolerability of the drug."

Stephen Senn, professor of statistics at the University of Glasgow and chairman of the working party, said, "The fact that so many volunteers simultaneously suffered severe reactions clearly signalled that the design of the TGN1412 trial might have been deficient."

He considered that many early phase studies lack clear aims or plans for analysis. "Researchers are uncertain about what they are going to find, so they don't document in detail the study design or how they will analyse what they find."

The working party recommended that phase I, "first in man," studies should be designed and described much more carefully. This should include quantitative justification of the starting dose based on appropriate preclinical studies and relevant calculations; assessment of the risk level for the recommended study dose; and appraisal of the uncertainty about these recommendations.

Documentation of this information should be given to the ethics committee, study participants, and insurers. Volunteers taking part in trials should be fully informed about possible risks. See Observations, p 566-7.

The *Report of the Working Party on Statistical Issues in First-in-Man Studies* is at www.rss.org.uk/first-in-man-report.

Lilly's challenge to Australia's drug rationing scheme fails

Bob Burton CANBERRA

Eli Lilly Australia has failed to overturn the repeated rejection of its osteoporosis drug teriparatide (Forteo) from being included in the government's drug subsidy scheme. An independent review, requested by the company, dismissed the clinical data in Lilly's submissions as inadequate.

The review was seen as a test case on whether a change, introduced through the Australia-US free trade agreement, would make it easier to overturn decisions made by the Pharmaceutical Benefits Advisory Committee. That committee decides which drugs are included in Australia's pharmaceutical benefits scheme, under which patients receive them at a subsidised rate (*BMJ* 2006;333:1239).

If Lilly's drug teriparatide had been approved under the scheme, patients would have paid a maximum of $A30.70 per prescription, with the government paying the rest of the cost. A year's supply of the drug costs about $A10 000 (£4000; €5900; $7800).

In June 2003 and March 2004 the committee rejected the company's applications for the approval of teriparatide as a second line treatment after the failure of antiresorptive therapy. In July 2005 Lilly's request that the drug be approved for treating severe forms of vertebral fractures was also rejected, as was Lilly's later request that it be approved for treating severe fractures.

LIBBY WELCH/PHOTOFUSION

Laughter, learnt of friends

Annabel Ferriman BMJ

Claire Holland (left) and Tracey Butler are friends and colleagues who work for a company called Raise! Mental Health, a training company dedicated to raising awareness of mental health issues. Tracey is Claire's boss.

All company members have, or have had, a mental health problem—in Claire's case bipolar disorder and in Tracey's case schizophrenia.

The pair has been photographed for a poster, entitled *Laughter*, by Stephen Rowell to celebrate mental health action week (8-14 April). The week is being organised by the Mental Health Foundation.

To order free copies of the posters or booklets email info@mhf.org.uk.

Exempt MRI scanners from new EU rules, say campaigners

Rory Watson BRUSSELS

Medical specialists, patients' groups, and European parliamentarians launched a campaign last week to ensure that new EU health and safety legislation will not restrict the use of magnetic resonance imaging (MRI).

The Alliance for MRI fears that new Europe-wide measures, which are designed to protect employees from short term exposure to electromagnetic fields, will inadvertently make it harder to use equipment to diagnose and treat illnesses from cancer and heart attacks to strokes and brain tumours.

The legislation will limit the time that operators may spend near MRI machines when in use. The alliance warns that this will make it more difficult for medical staff to help patients such as children and elderly people during scans and would stop the use of MRI for surgical procedures.

The European Commission is writing to EU governments to inform them that it is closely monitoring the situation. It confirmed to the *BMJ* this week that if new substantial evidence emerged that medical procedures could be unduly affected it would consider ways, including an amendment to the EU legislation, to address the problem.

Gabriel Krestin, professor of radiology at Erasmus University Medical Center in Rotterdam, estimates that the new restrictions might affect up to eight million MRI examinations in the European Union every year. He calculates these would include 400 000 procedures involving children or very ill people and 80 000 patients under anaesthesia. He thinks the legislation will make the examination of many patients with life threatening illnesses practically impossible.

Nicholas Gourtsoyiannis, president of the European Society of Radiology, which is one of the alliance's founding members, said at the launch, "It is essential that this major advance in healthcare technology is not threatened by burdensome legislation when concerns can be addressed through responsible guidance."

The Alliance for MRI points out that this important medical tool has been used safely for 25 years. It wants implementation of the legislation, which is due to operate from April 2008, to be frozen until the findings of a European Commission impact assessment are known later this year.

WHO confronts Chinese company over malaria drug

Anne Glusker GENEVA

The World Health Organization is asking a Chinese pharmaceutical company to stop making a malaria drug that earns millions of dollars annually in revenues.

The move is part of a campaign to combat increasing resistance to antimalarials and to promote use of combination treatments. The drug's manufacturer, Kunming Pharmaceutical, which is owned by the Holley Group and publicly traded on the Shanghai Stock Exchange, is refusing to halt sales, which amounted to $5m (£2.6m; €3.8m) in 2004, according to the *Wall Street Journal* (http://online.wsj.com, 6 Mar, "China's pride on line in malaria clash").

JEAN-MARC FERRE/WHO

Will Dr Margaret Chan be able to stand up to China?

The confrontation may prove awkward for Margaret Chan, the newly elected director general of WHO, who is from Hong Kong. One of the questions raised about Chan's candidacy was whether or not she would be able to stand up to China when necessary.

Kunming's drug is based on artemisinin, which is derived from a plant used in Chinese traditional medicine for centuries. Chinese scientists developed the drug, and Kunming introduced its product in the 1980s.

"This is not fair to China," Yu Zelin, general director of international trade at Kunming, told the *Wall Street Journal*. "We have developed the drug ourselves. We have made so much effort."

But with resistance to malaria drugs such as chloroquine, sulfadoxine-pyrimethamine, and amodiaquine on the rise, and between 300 and 500 million cases of malaria (and a million deaths) a year, WHO's malaria chief, Arata Kochi, has stepped up the campaign to stop drug companies selling monotherapies, which WHO believes lead to drug resistance.

TB and AIDS researchers fail to work together, article says

Michael Day LONDON

A rift between doctors in the HIV and tuberculosis communities is undermining the fight against both diseases, an article in *Nature Medicine* has claimed (2007;13:268-70).

As HIV infection rates continue to rise and Africa witnesses the alarming spread of extensively drug resistant tuberculosis (XDR TB), the two research communities are failing to combine forces against what is effectively a dual epidemic in many parts of the developing world.

Tuberculosis is the leading cause of death among people infected with HIV, and in some African countries about 60% of people with tuberculosis are also HIV positive.

Despite this, the report in *Nature Medicine* says that HIV and tuberculosis researchers are failing to collaborate—and cannot even agree on the extent of the threat posed by side effects to the treatments they provide.

A leading concern among doctors in the field is an emerging condition called immune reconstitution inflammatory syndrome (IRIS) in patients with tuberculosis who receive anti-HIV drugs, which affects about 20% of them.

These patients develop serious stomach abscesses and brain lesions and some die. "Nobody knows how to deal with it," said Robert Wilkinson, of the University of Cape Town.

Paul Nunn, of the World Health Organization's Stop TB programme, is more dismissive: "This is what you find when you talk to academic researchers whose job it is to go and look for problems," he told *Nature Medicine*, adding that IRIS had yet to be properly defined either clinically or in terms of its global impact.

See www.nature.com/nm/index.html, www.unaids.org/en, and www.who.int/tb/about/en.

IN BRIEF

Poorer women fare worse with breast cancer: Women from more deprived backgrounds are likely to wait longer to be seen and are diagnosed with more advanced breast cancer than women from more affluent backgrounds, a study by Cancer Research UK has found (*British Journal of Cancer* 2007;96:836-40). The study looked at 13 000 women and found that those from the most deprived areas were less likely to have a lumpectomy and radiotherapy and had a lower five year survival than women from richer areas.

Hospital restrictions on mobile phones should be lifted: Mobile telephones do not interfere with medical equipment when used normally in hospitals, according to a study in the *Mayo Clinic Proceedings* (2007;82:282-5). The investigators, who call for a revision of restrictions on their use, examined telephones from two different service providers in patients' rooms containing a total of 192 medical devices such as electrocardiographs, ventilators, and ultrasound imaging machines. In 300 tests, they found no instances of interference. Two personal digital assistants tested 40 times near 24 medical devices caused no problems either.

Global fund saves 1.5 million lives: The Global Fund to Fight AIDS, Tuberculosis and Malaria has announced that the lives of more than 1.5 million people worldwide have been saved as a result of programmes supported by the fund during its first five years in existence. For country by country details see www.theglobalfund.org/en/in_action/events/tgf_5years.

Hungarian hospitals face closure: Hungary is to close three major hospitals and reorganise many others, saving 10 000 hospital beds and cutting thousands of healthcare jobs. The closures announced by the health minister Lajos Molnár will affect Svábhegy Children's Hospital, the National Psychiatry and Neurology Centre, and Schöpf-Merei Ágost Hospital, all in Budapest.

Government launches inquiry into deaths of people with learning difficulties: The UK Department of Health is holding an inquiry after the charity Mencap highlighted six deaths of people with learning disabilities in NHS care. Mencap says there is a lack of training and understanding in the NHS of how to care for people with learning difficulties.

More evidence shows better outcomes for vascular surgery at high volume hospitals

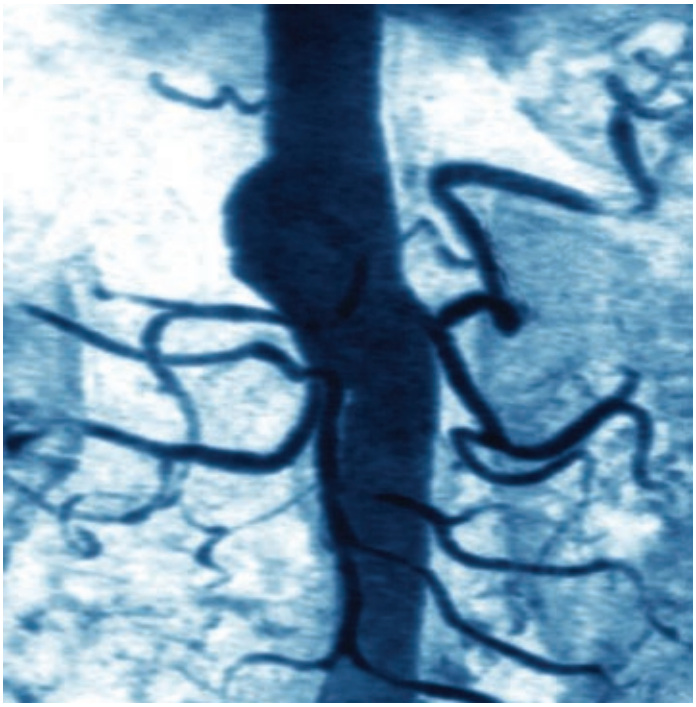
Roger Dobson ABERGAVENNY

Patients with abdominal aortic aneurysms have better chances of survival when they are operated on at hospitals that handle large numbers of cases, a new report shows.

Having elective surgery at hospitals with the greatest volume—those doing more than 32 repairs a year—reduced the odds of mortality by a third compared with the lowest volume centres, say researchers in the *British Journal of Surgery* (2007 Mar 14, doi: 10.1002/bjs.5725).

"Our research adds to the evidence that concentrating surgical resources in large centres of excellence can provide great benefit to patients. A bad outcome in this type of surgery is death, and specialist centres are best placed to prevent it," said the lead author, Peter Holt, of the Vascular Institute at St George's Hospital, London.

In the study, the authors used hospital episode statistics for 2000-5 to investigate the relation between the annual number of repairs done by a hospital and the outcomes of surgery. The results show that between April 2000 and March 2005 there were 112 527 diagnoses or repairs of aortic aneurysms (pictured) in the United Kingdom.



SOVEREIGN, ISM/SPL

The researchers then quantified the effects of transferring services to higher volume hospitals and the number of excess deaths with the current arrangement of services: "Elective surgery at hospitals that performed fewer than 32 repairs per year resulted in 46 excess deaths per annum, or 15 per 1000 cases," they say.

For urgent repairs, a significant reduction in mortality was also seen with greater annual volume. However, there was no reduction in mortality, complication rate, or duration of hospital stay with increased annual volume for ruptured aneurysms.

"There is an argument that volume criteria should be established for elective and urgent abdominal aortic aneurysm surgery in the UK. There would be significant financial implications for the funding of surgery, pressure on intensive care beds and the transfer costs of emergency patients," say the authors.

They add, "Although hospital volume and surgeon volume were independent predictors of death, with an additive effect, for other vascular procedures it has been demonstrated that low-volume surgeons can achieve similar results to high-volume surgeons when operating in a high-volume hospital, suggesting that hospital infrastructure is a key component in this relationship."

A second paper (doi: 10.1002/bjs.5710) reports the findings of a meta-analysis and systematic review that identified data from 26 studies, mainly from the United States, which together involved more than 350 000 patients.

The paper indicates that a centre needs to be performing surgery on at least 43 abdominal aortic aneurysms a year before it could provide significantly greater chances of success.

Results show that mortality fell as the number of operations increased: "This suggests that surgery should be performed only at higher-volume centres."

Audit identifies the most read *BMJ* research papers

Susan Mayor LONDON

Research studies on the side effects of commonly prescribed drugs constituted the three most read papers published by the *BMJ* in 2005, according to an internal audit that assessed their use by readers.

Studies that showed increased risk of myocardial infarction in patients taking cyclo-oxygenase-2 (COX 2) inhibitors and that explored the link between selective serotonin reuptake inhibitors and suicide came top. For the audit Sara Schroter, the *BMJ*'s senior researcher, analysed research papers using three measures: the number of citations a paper received, the number of times it was accessed on the web, and the number of rapid responses it generated.

The top scoring paper was a case-control study that showed greater risk of myocardial infarction in patients taking the COX 2 inhibitor rofecoxib (Vioxx) and in patients taking diclofenac and ibuprofen (2005;330:1366-9, doi: 10.1136/bmj.330.7504.1366).

The online version of this paper was accessed 42 505 times in the first year after publication. It received 28 rapid responses and was cited 97 times in 2005 and 2006.

At the time, there was widespread interest in the cardiovascular safety of COX 2 inhibitors after the withdrawal of Vioxx and the publication of several papers on the risk associated with these agents.

A meta-analysis of drug company data that showed no evidence that selective serotonin reuptake inhibitors increase the risk of suicide

LIBBY WELCH/PHOTOFUSION

Reid wrong about comfort of smoking, research shows

Roger Dobson ABERGAVENNY

Smoking is not associated with better quality of life or increased pleasure.

Results from a study that investigated links between smoking and pleasure and quality of life showed no evidence to support a controversial comment by the former health secretary John Reid (now the home secretary) that for some people their only enjoyment was having a cigarette (*Public Health* 2007 Mar 2, doi: 10.1016/j.puhe.2007.01.005)

"We found no evidence to support a claim that smoking is associated with heightened levels of pleasure, either in low socioeconomic groups or in the general population. In fact, our results suggest the opposite…

"As a group, smokers have lower levels of pleasure and quality of life than those who have never smoked, with ex-smokers in between," say the authors.

To see whether pleasure and better quality of life were associated with smoking, the team from Peninsula Medical School in Exeter and Cambridge University analysed data from a study of 9176 men and women aged 50 years or more who took part in the health survey for England.

The survey data they used included details about past and present smoking habits and household wealth as a marker for socioeconomic position. A quality of life test included items assessing pleasure. Typical statements that participants were invited to agree or disagree with were "I look forward to each day" and "I enjoy the things that I do."

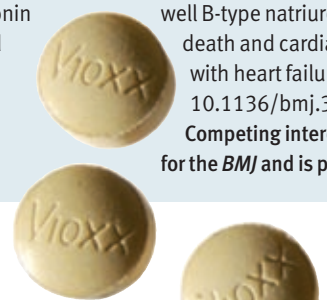
The odds ratio for experiencing lower than median levels of pleasure for smokers in low socioeconomic groups was 1.42 (95% confidence interval 1.16 to 1.74), and for all smokers it was 1.33 (1.17 to 1.51).

but found weak evidence of increased risk of self harm was ranked second (2005;330:385-10, doi: 10.1136/bmj.330.7488.38). This was accessed almost 24 000 times and was cited 78 times in 2005 and 2006.

In third place was a systematic review that showed an association between suicide attempts and the use of selective serotonin reuptake inhibitors and that highlighted limitations in the reporting of suicides in clinical trials (330:396-403, doi: 10.1136/bmj.330.7488.396).

Other studies in the top 10 addressed practical issues, including a trial of calcium and cholecalciferol for prevention of fractures (2005;330:1003-6, doi: 10.1136/bmj.330.7498.1003), a prospective study of cannabis use and psychotic symptoms in young people (2005;330:11-4, doi: 10.1136/bmj.38267.664086.63), and a review of how well B-type natriuretic peptide predicts death and cardiac events in patients with heart failure (2005;330:625-7, doi: 10.1136/bmj.330.7492.625).

Competing interests: SM writes regularly for the *BMJ* and is paid for her contributions.



DANIEL HULSHIZER/AP PHOTO

Doctors sign petition calling for euthanasia to be decriminalised

Brad Spurgeon PARIS

More than 2000 doctors, nurses, and other health workers have published a petition in a French news magazine admitting to having assisted the deaths of terminally ill patients at some time in their careers (*Le Nouvel Observateur* 2007 March 8:98).

The petition was published four days before a trial opened in Perigueux, in south west France, of a doctor and a nurse accused of killing a 65 year old patient who was terminally ill with pancreatic cancer by administering a lethal dose of potassium in August 2003. If they are found guilty, the two risk up to 30 years in prison.

The petition (www.nouvelobs.com) calls for an immediate end to the legal pursuit of health workers for euthanasia; an immediate change in the law, to decriminalise euthanasia and allow it under certain circumstances, as in Switzerland, Belgium, and the Netherlands; and a call for appropriate methods to accompany patients at the end of life, whether it be in the home, hospitals, or retirement homes, and with dignity.

"We, medical workers, have, consciously, medically assisted patients to die with decency," said the petition. It added that while not all medical workers are confronted with such a dramatic situation, the majority of them do regularly help their patients die, using "chemical substances that speed up an end to life that is otherwise too cruel, knowing full well that this is currently against the law."

The petition comes during the country's presidential election campaign, at a time when both leading candidates, Nicolas Sarkozy and Ségolène Royal, vowed to open the debate on euthanasia if elected.

The petition was led by Dr Denis Labayle, of a hospital in Courcouronnes, near Paris, and it recognises the improvements brought about by the Leonetti law of April 2005, which allows doctors under certain circumstances to stop treatment and let patients die. It said that the Leonetti law does not go far enough (*BMJ* 2004;329:1307, 4 December doi: 10.1136/bmj.329.7478.1307).

The French Society for Accompaniment and Palliative Care launched an immediate counterattack on the petition with another petition on the internet at www.sfap.org. That petition calls for signatures from health professionals and organisations that oppose euthanasia.

Organ recipients may die when insurance for drugs runs out

Fred Charatan FLORIDA

Young transplant recipients who lose their insurance coverage are more likely to stop taking essential anti-rejection drugs, which can increase their risk of organ loss and death, a new study shows (*Pediatric Transplantation* 2007;11:127-31).

"Kids with transplanted kidneys who lose their insurance have a nine times greater chance of dying than those who don't," said leading author Mark Schnitzler, associate professor in the departments of internal medicine and community health at St Louis University.

"Immunosuppressive drugs that prevent organ rejection are incredibly expensive; sometimes more than $13 000 (£6700; €9900) a year. Even for families with insurance, the co-payments can be a huge financial burden," he added.

"It is critical that we find a way to offer lifetime access to these children"

In the United States, Medicare pays for most organ transplants. However, coverage of immunosuppressant drugs ends 36 to 44 months after surgery, or when the patient reaches adulthood. Only about 30% of young adults have health insurance. For people who have employer sponsored or private health insurance, coverage ends once a patient reaches a lifetime maximum amount stipulated by their policies.

As a result of these factors, many organ recipients stop taking immunosuppressant drugs; transplanted organs are rejected and patients' lives are shortened. Dr Schnitzler and his team studied the medical records of 1001 children who received a donor kidney between 1995 and 2001, half of whom lost their health insurance.

Dr Schnitzler said: "It is critical that we find a way to offer lifetime access to these children and their families so that our society does not continue to prematurely lose this promising pool of young adults."

"Pediatric transplant recipients have every desire to become independent and useful members of society."

He and his colleagues concluded that new public policies requiring lifetime healthcare coverage for organ transplant recipients would be cost effective, and would prolong patients' lives.

Spending watchdog slates doctors' out of hours provision

Lynn Eaton LONDON

Doctors were the only winners from changes in 2004 to out of hours provision, states a report from the government's spending watchdog, the Public Accounts Committee.

As far as patients are concerned, they lost out—not only because of a reduction in the quality of the service, but because of the additional financial burden on them as taxpayers, says the report.

The findings, published on Wednesday, look at the changes in GP out of hours cover introduced in 2004. Before then, GPs provided the cover themselves, either by pooling together to operate as a cooperative when their surgeries were closed or by paying for a commercial deputising service. After 2004, they were able to opt out of this arrangement. Instead they paid £6000 a year to their local primary care trust (PCT), which took over responsibility for the provision. An additional amount was paid to PCTs from the Department of Health towards the service.

But preparations for the new arrangement were shambolic, says the committee. Although the service is starting to improve, performance against key targets, such as the time taken before patients are seen by the doctor, is still low. And it is costing £70m (€102m; $135m) a year more than expected, says the report.

"The Department of Health thoroughly mishandled the introdution of the new system of out of hours care," said Edward Leigh MP, chairman of the committee.

He said doctors were given a strong incentive to opt out—in that they could do a lot less work for a small loss of income.

"To cap it all, the cost of the new out of hours service is around £70 million a year more than was expected. That's the last thing the primary care trusts need at this time of increasing financial pressure."

According to the committee, about nine million patients receive urgent primary out of hours care in England every year between 6 30 pm and 8 am on weekdays, at all times during weekends, and on public holidays.

The report criticises the Department of Health for failing to explain to PCTs whether the service was for urgent cases only or for all requests for help. And it says the £6000 annual fee for doctors who chose to let their PCT provide cover was a "serious underestimate" of the likely costs—even when it was partly topped up by the health department.

Hamish Meldrum, chairman of the BMA's General Practitioners Committee, commenting on the report, said, "Family doctors had been taken advantage of for years, working long hours on the cheap. When, with the full agreement of the government, primary care organisations took over responsibility for providing the [out of hours] service and in some places failed to make a good job of it—they try to blame the GPs. It's not right and it's not acceptable.

"We want patients to have high quality, safe services around the clock, staffed by doctors who are not worn out from having done a full day's work before they start an evening or weekend shift.

MARTIN RICKETT/PA/EMPICS

Phil Willis wants to ensure that money meant for research is not diverted to other purposes

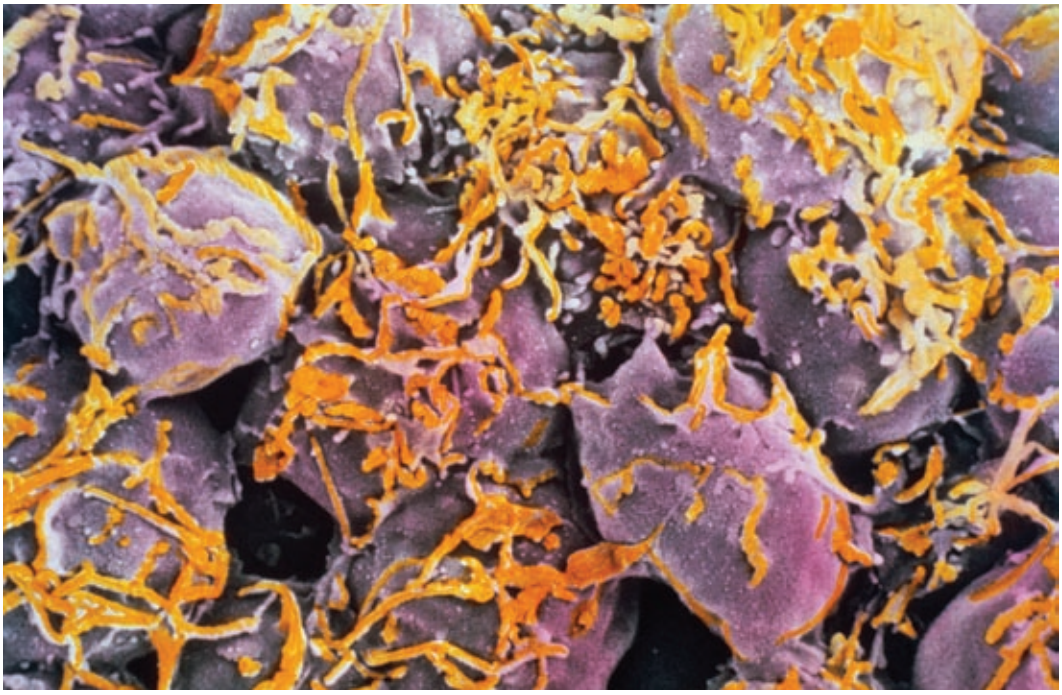
MPs broadly welcome

Zosia Kmietowicz LONDON

A review by MPs of proposals on how £1bn (€1.5bn; $1.9bn) worth of publicly funded health research should be allocated in the United Kingdom has raised concerns about introducing targets to set research priorities.

The cross party Science and Technology Committee has broadly welcomed the conclusions reached by Sir David Cooksey in his review published in December (*BMJ* 2006;333:1239, 16 Dec) on how healthcare research can be improved to bring more tangible benefits to patients.

The committee says it has reservations about



MOTTA & MAKABE/SPL

Doctor's licence suspended after he admitted removing hundreds of ova without consent

Judy Siegel-Itzkovich JERUSALEM

One of Israel's leading fertility experts and a former chief of gynaecology at one of its largest public hospitals will lose his medical licence for two and a half years after admitting that he removed hundreds of ova from private patients at the Herzliya Medical Centre without permission and without registering the procedures in their medical records.

Zion Ben-Raphael, formerly a department head of the Rabin Medical Centre-Beilinson Campus, will be punished following a ruling by retired Jerusalem District Court president Judge Vardi Zeiler, who is responsible for deciding cases after medical personnel appear before a health ministry disciplinary panel.

The case, which induced the government to alleviate the shortage of donor ova by changing the law to allow women not undergoing fertility treatments themselves to donate ova altruistically, has dragged on for seven years. The process, which never went to court, included a plea bargain with the state attorney's office in which Professor Ben-Raphael admitted guilt. The case was one of the country's most serious involving a gynaecologist.

The 57 year old doctor admitted that between 1996 and 1999 he took hundreds of ova from private patients undergoing fertility treatments—without their permission. He produced extra ripened eggs in some of them by using hormones to overstimulate the women's ovaries, which can be dangerous. In 2000, he was also caught paying $20 000 (£10 400; €15 000) to a man who posed as a policeman in exchange for promises that the criminal file against him would be closed.

Professor Ben-Raphael removed 232 ova from one woman without her permission and used 155 of them for in vitro fertilisation of 33 infertile women. In another case, 53 eggs were surgically removed, and 30 were used.

He took 256 ova from a third patient, and 181 of them were used for fertility treatments in 34 women. Even when women agreed to donate extra eggs, he removed more of them than he said he would. In none of these cases was the taking of eggs recorded in medical files. In total, six women filed police complaints against him.

Ameliorating circumstances cited by Judge Zeiler for the relatively mild punishment included the fact that the doctor had given years of "impressive service" to the Israel Defense Forces.

proposals for health research in United Kingdom

some aspects of the proposals, however, and will be taking "a close interest in reviewing progress and how the new institutional arrangements will work in practice."

In his review, which was commissioned by Gordon Brown, the chancellor of the exchequer, Sir David proposed creating two new bodies to deliver a research strategy that brings together the two separate funding streams for public health research in the UK—the Medical Research Council (MRC) and the NHS's National Institute for Health Research.

One of the new bodies, the Office for Strategic Coordination of Health Research, will be the central coordinating body for all health research, responsible for setting the research budget and identifying projects that address unmet needs. It will bid for treasury money and allocate it as it sees fit to the Medical Research Council and the National Institute for Health Research. The other body—the Translational Medicine Funding Board—will direct money towards projects that promise heath benefits and innovation.

Phil Willis, chairman of the committee, said, "The committee wishes to see all funding allocated to health research used for that purpose. This has not always been the case in the past with NHS funding.

"The Cooksey Review proposals offer a sound basis for the implementation of the single fund for health research."

The committee expressed concern, however, that the Office for Strategic Coordination of Health Research (OSCHR) would set targets and objectives for the Medical Research Council and the National Institute for Health Research to define research priorities. MPs were worried that the office would adopt a top down approach.

***The Cooksey Review* is available at www.parliament.uk/s&tcom.**